MONTANA BOARD OF DENTISTRY
301 SOUTH PARK 4TH FLOOR
PO BOX 200513
HELENA, MONTANA 59620-0513
(406) 841-2390 Fax (406) 841-2305
E-Mail: dlibsdden@state.mt.us
http://mt.gov/dli/den

CERTIFICATION OF HOURS
FOR REINSTATEMENT OF REACTIVATION

NAME:_____

DATE:_____

Employer Name:_____

Dates Worked: From:_____To:_____

☐Full Time OR ☐ Part Time AND Hours per week_____

Employer Signature:_____Date:_____

If you have had more than one employer during this period of time, the applicant must have one signed by each employer verifying work experience. You may make copies of this form.

_____
Employer's Address: Phone Number:

I hereby certify that the information submitted on this form is true and complete to the best of my knowledge. In signing this form, I am aware that a false statement or evasive answer may lead to denial of my application or subsequent revocation of licensure on ethical grounds.

Applicant Signature:_____

Date:_____